Primary Care Reimbursement of After Hours Care by Commercial Insurance Payers

Study to support the work of the Maryland Health Care Access and Reimbursement Task Force

September 8, 2008

Purpose and Overview

Legislation passed during the 2008 session of the Maryland Legislature expanded the charge of the Task Force, requiring it to provide recommendations on whether primary care physicians (PCPs) should be allowed to receive a premium for providing after hours care. A recent report on the use of Maryland hospital emergency departments found that a large percentage of patients are utilizing the emergency department that could have been treated by their PCP. This may reflect the lack of access to PCPs after hours and failure to adequately compensate PCPs for the additional burdens of providing after hours care. The purpose of this study was to gather information to support the Task Force in assessing the advantages and disadvantages of improving compensation to PCPs who provide after hours care. The specific issues investigated include the following:

- Definition of after hours care
  - How is 'after hours care' defined (e.g., any service provided after 5 pm or on weekends)?
  - Would non-face-to-face (e.g., phone, emails) communications be included?
- After hours services in Maryland
  - Are there any sources of information on the extent of after hours care currently being provided in Maryland?
  - Is there any information on use of urgent care centers and retail clinics in the state and whether they are meeting patient demand for after hours care?
- Payment for after hours care
  - What are carrier policies/views?
  - How would payment be structured?
    - Would an elevated payment for after hours care be part of the medical homes construct?
  - What is the likely extent of substitution for ED care? Would this result in cost savings?

Definition of After Hours Care

<u>How is 'after hours care' defined (e.g., any service provided after 5 pm or on weekends)?</u>
A universally accepted definition for after hours care has not been developed, reflecting the limited amount of published and unpublished literature in the U.S. about this important topic to basic health care delivery. One definition describes after hours care as "services designed to meet

the needs of patients experiencing a health problem that cannot be safely deferred until regular primary care services are available".[1] This definition is important to review because it fails to consider a number of practical issues.[2]

- It may be difficult for patients to determine when treatment can be safely postponed.
- Physicians, patients and parents may have differing perspectives on what constitutes need, particularly when symptoms such as pain are troublesome.
- The need for reassurance that a medical condition is not dangerous.
- Lack of availability of primary care appointments may lead patients to use after hours care when they would prefer to be seen by a PCP during usual office hours.
- Hourly employees who are unable to leave the workplace during the day may have to choose between jeopardizing their job or losing income to schedule a daytime PCP appointment, or seeking treatment in the emergency department after work hours.

If the purpose of addressing after hours care is to develop solutions that will reduce inappropriate use of overcrowded emergency department then a more liberal definition of after hours care should be adopted that encompasses any condition that leads a patient or parent to seek care outside of standard work week hours. Under this definition, PCPs that schedule evening appointments would be considered to be providing after hours care. Including evening appointments in the definition of after hours care encourages PCPs to extend their hours of coverage beyond the standard work day.

Would non face-to-face (e.g., phone, emails) communications be included?
The most efficient use of limited health care resources would further define after hours care as including not only face-to-face visits but also communication by telephone, and e-mail that would replace a face-to-face appointment. The limited number of primary care providers in rural areas makes the provision of 24/7 face-to-face care difficult to unachievable, and financially unsustainable given the low patient numbers. Electronic communications and telephone advice from physicians and nurses are an important component of a 24/7 after hours access system and can prevent unnecessary visits to emergency departments. Lack of payment incentives, however, discourage overextended PCPs from developing creative approaches to providing patient coverage after traditional work hours. Without any mechanism to be compensated for non face-to-face visits, physicians loose income if they manage a patient's problem over the telephone and with email communications rather than bringing the patient in for an office visit.

After Hours Care in Maryland

Is there any information on use of urgent care centers and retail clinics in the state and whether they are meeting patient demand for after hours care? At least 62 after hours services in addition to hospital emergency departments are located in Maryland; all but seven are clustered in the Central and Capitol Areas and most are not associated with primary care practices. No data are available on the annual number of patients treated by retail clinics and urgent care centers. The high use of Maryland hospital emergency department by non-emergent patients implies that the availability of after hours services is insufficient to meet the demand. A 2007 report to the Maryland Health Care Commission on use of Maryland hospital emergency departments concluded that one-third of visits to hospital emergency departments in 2005 did not require

emergency department care.[3] Although retail clinics and urgent care centers offer important services after hours to meet immediate needs, these approaches do not replace the personalized treatment that can be provided by a primary care physician who knows the patient's medical history and psychosocial background, particularly when patients have complex medical problems.

Retail Clinics: The first retail clinic opened in Maryland in 2002, and now at least twenty five retail clinics are located in CVS and Target stores in the Central and National Capital regions but not elsewhere. Nurse practitioners and sometimes physician assistants provide treatment governed by standardized guidelines for minor, short-term illnesses that require no or minimal follow-up and offer preventive health screenings. Retail clinics are appealing to consumers because of extended hours, convenient locations, efficiency, the option of walk-in care or scheduled appointments and the posting of a menu of services with a price list. Standards established by the Convenient Care Association, the professional trade association of retail clinics, call for ongoing internal and external peer review of care, physician review of care, use of evidence based guidelines, monitoring of quality indicators, and use of electronic health records.[4] Retail clinics, structured to serve a small segment of the market that is less sick, are not a mechanism to serve all patients with after hours care needs.[5]

Urgent Care Centers: In Maryland, urgent care centers operate in the following regions: Central (22), National Capital Area (8), Southern (1), Western (3) and Eastern Shore (3).
Urgent care centers are equipped to treat non-life threatening illnesses and injuries with the support of on-site radiology services and a medical laboratory. Unlike retail clinics, urgent care centers have the personnel and equipment to diagnose and treat more complex medical conditions as well as to suture, and set simple fractures. In contrast to emergency departments, urgent care centers treat lower acuity conditions and are not legally mandated to provide care to the uninsured. Over half of the urgent care centers in the Central region are operated by one company which also manages traditional primary care practices in the same location. Urgent care services are provided seven days a week, at least 10 hours a day.

Payment of After Hours Care

What are carrier policies/views: Most commercial payers in Maryland and across the country do not compensate PCPs for phone or e-mail communications (eVisit) or pay a premium for after hours face-to-face visits.This practice is slowly changing in response to the crisis in emergency department overcrowding and the Institute of Medicine's focus on timely care as an essential pillar of quality care.[6] Several practices are worth noting.

- eVisits: Aetna, Blue Cross Blue Shield and Cigna pays for eVisits in some markets. After logging on to a HIPAA compliant, secure internet platform, the patient starts an eVisit with their physician by answering a detailed, logic driven set of questions related to their specific health condition. The patient's initial request must meet established eVisit criteria. The physician responds with an appropriate course of action. The encounter is fully documented for the medical record and an eVisit charge is processed through the billing system to the patient's insurance company.

- After hours visits: United Healthcare reimburses for after hours CPT codes 99050 and 99058 when submitted with basic service codes. Care must be provided outside of normal posted office hours or result in the disruption of the physician's regular practice during office hours. The after hours policy is intended as an alternative to more costly emergency department or urgent care center services.
- CareFirst recently began a pay-for-quality program that includes extended hours as one of the criteria for receiving points. Internal medicine, family medicine and pediatricians who meet all criteria in the program can receive up to a 7% increase to the fee schedule.

How would payment be structured? There are two potential payment approaches to encourage PCPs to provide after hours care and to fairly compensate physicians for the additional resources and effort required: fee for service and payment as a component of the medical home.

Fee for service: CPT codes have been developed to enable physicians to bill for after hours face-to-face visits, phone consults and eVisits. Table 1 describes the CPT codes for each service venue.

After hours CPT codes (99050-99060) are billed in addition to the usual evaluation and management (E/M) codes for physician face-to-face visits. The after hours codes specify several scenarios: 1) the provision of services during nonscheduled office hours when the office is normally closed, 2) scheduled hours that are in the evening and on weekends and holidays, and 3) a visit outside of the office and an emergency visit during office hours which leads to a disruption in scheduled patient visits.

Telephone service codes (99441-99443) are billed for phone calls initiated by an established patient or the patient's guardian to a physican in which medical services are provided. The code billed is dependent on the time required to address the patient's needs.

An eVisit is an online medical evaluation of a patient by a physician constituting a series of e-mails addressing a health issue. An eVisit is billed using service code 99444. Telephone consults and eVisits cannot be billed if conducted as follow-up to a visit or immediately preceding a scheduled visit.

Table 1: CPT Codes Relevant to After Hours Care

Venue	CPT Code	Description
Face to face after hours encounter	99050*	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed
	99051*	Services provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
	99056*	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic

Venue	CPT Code	Description
		service.
	99060*	Services provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service.
Telephone consult	99441	Telephone E/M service provided by a physician to an established patient, parent, or guardian not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of medical discussion
	99442	Same as 9941 except call includes 11-20 minutes of medical discussion
	99443	Same as 9941 except call includes 21-30 minutes of medical discussion
Electronic visit (e-visit)	99444	Online evaluation and management service provided by a physician to an established patient, guardian, or healthcare provider not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network

*In addition to E/M codes.

Payment reform:

<u>Would an elevated payment for after hours care be part of the medical homes construct?</u>

Advocates for payment reform strive to correct the failure of the fee for service system to reward higher quality, lower cost healthcare that values coordination, efficiency and prevention. In the statement, "Joint Principles of the Patient-Centered Medical Home" (2007), published by the American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association, enhanced access with open scheduling, expanded hours and non face-to-face modes of communication is identified as an integral component to the medical home construct. In a medical home model, a PCP coordinates and facilitates a patient's care using evidence-based medicine and clinical support tools to create an integrated, coherent plan for care. There is a lack of consensus as to whether medical home should be applied to special populations only or to all patients, and if physician compensation should be made using a fee-for-service premium or a per member per month captitated payment. Unlike a capitation system of payment, payment for medical home services is adjusted for patient risk, outcome measures that monitor quality, and the costs associated with a more comprehensive health care team and added infrastructure.[7]

Physician practice size and limited resources are major barriers to widespread implementation of the medical home concept in the near term. Most physicians are in practices with four or fewer physicians[8] and lack the basic infrastructure of people, technology, space and capital to meet the medical home requirements. A scaled approach to medical home payment could be adopted that

rewards physicians for incremental changes towards transforming their practice into a medical home with after hours care as one component of coordinated care that is worthy of incentives.

Reduction of Emergency Department Use and Costs

What is the likely extent of substitution of emergency department care?

Lack of access to primary care providers after hours is an important barrier to high quality care in the U.S., where 60% of primary care physicians report not offering arrangements in which patients can be seen by a physician or nurse if needed when the practice is closed.[9] An equal number of adults (60%) report having difficulty getting care on nights, weekends or holidays without going to the emergency department.[10] Limited availability of after hours primary care is most likely a contributing problem to the overburdened emergency medical system in Maryland. Almost 35 percent of Maryland emergency department visits in 2005 were classified as either non-emergent or emergent (i.e., requiring care within 12 hours) but could have been treated in primary care settings.[3] An earlier study of a Maryland managed care population found that 38% of patients that had three or more visits to the emergency department in a year, not resulting in admission, were commercially insured.[11] A recent national study found that patients whose usual source of care was a physician's office accounted for a rising percentage of emergency department visits (52.4 percent in 1997 to 59.0% in 2004) whereas the percent of visits by patients without a usual source of care was essentially unchanged (9.7% of visits in 1996 to 1997 and 9.6% in 2003 to 2004).[12]

Expanding after hours care in primary care is one solution to diverting care from overburdened emergency departments. A case study of a family medicine practice that provides a comprehensive after hours service reported 52 percent fewer emergency department visits among patients of physicians offering after hours care compared to patients seeing physicians whose practice did not provide this service (Appendix A).[13]

Would this save costs?

Inappropriate use of emergency departments leads to not only misuse of scarce services but also scarce healthcare dollars. In 2003, the median emergency department expense was almost five times greater than an office-based visit ($299 vs. $63).[14] Some argue that short term saving would not be expected for care provided at night when the costs incurred by emergency care are marginal compared to the expense of opening a physician's office for one patient.[15] However, even at night, treatment by a PCP, who is familiar with the patient's medical history and can provide follow-up care may lead to the prevention of more serious complications and costly treatment at a later date. Compensation for more cost efficient non face-to-face medical evaluation to address unanticipated, nonurgent healthcare problems offers further potential for savings that has not been evaluated to date. Costs to increase the capacity of overstretched emergency facilities in Maryland should also be considered. Hospitals may be forced to add additional emergency space, equipment and staff because resources needed by emergent patients are diverted to patients who are more appropriately treated by primary care.

Recommendations for Consideration

Recommendations

- Pay primary care providers a premium for visits after the end of the 5:00 p.m. work day and on weekends for scheduled and unscheduled appointments.

- Compensate primary care providers for telephone and electronic (eVisit) communications with patients that include evaluation and management services delivered at any time of the day or night.

- Take no action on primary care provider's payment for after hours care associated with the medical home. Provider payment for medical home services will incorporate a component for after hours care into the payment formula.

Rationale

- Substantial changes and consistent approaches to payment are needed to effect change in primary care physician practice that will significantly improve patient access to after hours primary care and reduce inappropriate use of the emergency department.

- There is an opportunity for significant patient, payer, physician and hospital gains if patients' medical and mental health problems are managed in a timely manner by primary care providers rather than relying on overcrowded emergency department as the default source of care.

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Appendix A

After Hours Case Study

Primary Care Partners, a group of 23 family physician and pediatricians in Grand Junction Colorado, developed an after hours clinic in a remodeled wing of the practice that consists of six exam rooms and two procedure room with lab and x-ray facilities nearby.[a] The clinic is managed by a nurse administrator and staffed by one physician with a second physician on call, 2 receptionists, one certified nursing assistant/nurse and one x-ray/lab technician. The clinic, which includes a nurse call triage system, is open from 5 pm to 10 pm on weekdays, all day on weekends' until 10 p.m., and on a flexible holiday schedule . Up to 50 patients belonging to the practice or their relatives are seen on weeknights and 60-100 on weekend days. The practice negotiated a facility fee with major insurers and one insurer agreed to reimburse at a higher rate for claims submitted with the after hours modifier. Insurers do not compensate for lab or x-ray services.

The after hours clinic has enabled the practice to schedule patients in the evening that cannot be fit into the daytime schedule, relieving the pressure to work patients into a busy schedule during the day. Emergency department utilization decreased and patients of the practice have fewer hospital days. Commercial emergency department visits were 86/1,000 for the practice compared to 178/1,000 for comparable practices in the community in 2002. Hospital days per 1,000 are 140/1,000 for the practice compared to 171/1,000 for comparable practices.

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